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Office of Administrative Law Judges
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Issue Date: 20 April 2006

Case Nos.: 2004-BLA-6261
2004-BLA-6563

In the Matter of:

CHRISTINE SMITH, Widow of
EDWIN S. SMITH, Deceased
Claimant

v.

EASTERN COAL CORPORATION
Employer

THE PITTSTON COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

William Lawrence Roberts, Esq.
For the Claimant

Lois A. Kitts, Esq.
For the Employer/Carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the "Act"). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

Ms. Christine Smith, represented by counsel, appeared at the formal hearing held October 18, 2005 in Pikeville, Kentucky. I afforded both parties the opportunity to offer testimony, question witnesses and introduce evidence. Thereafter, I closed the record. I based the following Findings of Fact and Conclusions of Law upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. Although the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformity with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, EX and CX refer to the exhibits of the Director, Employer and Claimant, respectively.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Edwin Stewart Smith filed his first application for black lung benefits in 1970. (DX 1-404). His claim was denied by the District Director on March 9, 1971. (DX 1-360). Mr. Smith filed a subsequent claim in August 1984. (DX 1-240). The District Director denied his claim on January 31, 1985. Upon reconsideration, the District Director issued another denial on January 20, 1987. (DX 1-2). Mr. Smith did not appeal the findings. He then filed the instant subsequent claim on August 1, 2001. (DX 3). However, Mr. Smith died on January 12, 2003. (DX 11). The District Director found that Mr. Smith proved all the issues of entitlement and awarded him benefits on March 12, 2003. (DX 36). Employer then requested a formal hearing. (DX 39). Claimant filed a claim for survival benefits on February 25, 2003. (DX 53). On January 23, 2004 the District Director awarded her benefits. Employer subsequently requested a formal hearing. (DX 73). Both claims were transferred to the Office of Administrative Law Judges on April 28, 2004. (DX 77, 78).

Factual Background

Edwin Smith ("the miner") was born on November 28, 1930. (DX 3). He had an eighth grade education. (DX 3). The miner was married to Christine Smith. (DX 3). He worked the majority of his career in coal mine employment driving a buggy and operating a pinner. (Tr. 13; DX 3). He left the mines on December 4, 1984, due to his breathing condition. (DX 3). Ms. Smith ("Claimant") testified that for the last ten to fifteen years of his life, the miner was on a breathing machine and oxygen. (Tr. 15). She stated that the miner was unable to walk without assistance due to his breathing condition. (Tr. 16-17). Prior to the miner's death, the couple resided in Kentucky during the summer months and Florida throughout the winter. (TR. 15).

At his deposition on December 11, 2001, the miner testified that he smoked one to one and-one-half packs of cigarettes per day for thirty years. (DX 18). He stated that he quit smoking in January of 1990. (DX 18). The medical evidence supports the miner's testimony. However, there is one notation in the medical records finding the miner was smoking in 1996. (EX 7). The miner died on January 31, 2003. (DX 11, 53).

Contested Issues in Miner's Claim

The parties contest the following issues regarding this claim:

1. Whether the miner's claim was timely filed;

2. Whether the miner had pneumoconiosis as defined by the Act and the regulations;

3. Whether the miner's pneumoconiosis, if present, arose out of coal mine employment;

4. Whether the miner was totally disabled;

5. Whether the miner's total disability, if present, is due to pneumoconiosis; and,

6. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(c), (d).

The employer also contests other issues that are beyond the authority of an administrative law judge and are preserved for appeal.[1]

Contested Issues in Survivor's Claim

The parties contest the following issue regarding this claim:

1. Whether the miner had pneumoconiosis as defined by the Act and the regulations;

2. Whether the miner's pneumoconiosis, if present, arose out of coal mine employment; and,

3. Whether the miner died due to pneumoconiosis.

The employer also contests other issues in the survivor's claim that are beyond the authority of an administrative law judge and are preserved for appeal.[2]

[1] These issues involve the constitutionality of the Act and the regulations. Administrative Law Judges are precluded from ruling on the constitutionality of the Act; therefore, these issues will not be ruled on herein but are preserved for appeal purposes.

[2] These issues involve the constitutionality of the Act and the regulations. Administrative Law Judges are precluded from ruling on the constitutionality of the Act; therefore, these issues will not be ruled on herein but are preserved for appeal purposes.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The miner's length of coal mine employment is an uncontested issue. The District Director made a finding of eighteen years in coal mine employment. (DX 36). The documentary evidence includes the miner's Social Security earnings report and an employment questionnaire. The evidence of record supports a finding of eighteen years in coal mine employment. Accordingly, based upon all the evidence in the record, I find that the miner was a coal miner, as that term is defined by the Act and Regulations, for eighteen years. He last worked in the Nation's coal mines in 1984. (DX 3).

Dependency

The miner alleged one dependent for the purposes of benefit augmentation, namely his wife, Christine. (DX 3). They married on December 24, 1954. (DX 52). The record includes their marriage certificate and Claimant testified to her dependency. (DX 52; Tr. 12-13). Accordingly, I find that the evidence of record supports a finding that the miner had one dependent for the purposes of benefit augmentation.

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

The miner filed two previous claims for benefits in 1970 and 1984. The record of the prior claims includes numerous medical opinion reports. The reports are discussed below.

Drs. O'Neil, Powell, Abernathy and Broudy all found the miner did not suffer from clinical or legal pneumoconiosis or a totally disabling respiratory condition.

William Anderson, M.D. diagnosed the miner with pneumoconiosis on April 9, 1985 and July 1, 1985. (DX 1-4). However, Dr. Anderson found, based on the miner's pulmonary function testing, that the miner had the respiratory capacity to perform his prior coal mine employment.

Ballard D. Wright, M.D. diagnosed the miner with pneumoconiosis on May 25, 1985. (DX 1-5). Dr. Wright based his opinion solely on a chest x-ray reading. He also diagnosed the miner with chronic obstructive pulmonary disease and chronic bronchitis associated with smoking. He did not attribute these conditions to coal dust exposure. Dr. Wright opined the miner had a mild restrictive ventilatory impairment, but made no findings on total disability.

Frank T. Varney, M.D. also diagnosed the miner with pneumoconiosis based solely on a chest x-ray reading. (DX 1-10). He made no total disability findings.

On May 16, 1985, Harvey A. Page, M.D. diagnosed the miner with pneumoconiosis based on a chest x-ray. (DX 1-13). He opined that the miner should be removed from the dusty atmosphere of mining and should not be permitted or required to work in a dust-related industry.

Robert W. Penman, M.D. also diagnosed the miner with pneumoconiosis in February 1985. (DX 1-17). He based his opinion on a chest x-ray and the miner's history of coal dust exposure. Dr. Penman states the miner had an impairment in his lung function but he failed to make a total disability finding.

These opinions do not support a finding of total disability due to pneumoconiosis. First a diagnosis of pneumoconiosis based solely on a chest x-ray is unreasoned. In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone does not tend to establish that

he has any respiratory disease arising out of coal mine employment. *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id*. Therefore, the above pneumoconiosis opinions are unreasoned.

Furthermore Drs. Wright, Varney and Penman made no total disability findings. Dr. Page merely advised the miner that he should not return to coal mine employment due to the diagnosis of pneumoconiosis. An opinion of the inadvisability of returning to coal mine employment because of pneumoconiosis is not the equivalent of a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.,* 12 BLR 1-83 (1988). Dr. Page made no finding that based on the miner's pulmonary condition he could not perform his regular coal mine employment. Therefore, the physicians' medical opinions are not well-reasoned medical opinions on the issue of total disability due to pneumoconiosis.

In order for a medical report to constitute notice, it must be a well-reasoned opinion that the miner was totally disabled due to pneumoconiosis. Therefore, I find that Employer has not rebutted the presumption of Section 725.308(c), and that this claim was timely filed. Furthermore, even if I had found the medical reports well-reasoned, the communication element is not satisfied. The fact that the medical reports are in the record, does not mean the communication requirement is satisfied. I am not inclined to assume that simply because a medical report was in the record or in the possession of Claimant's attorney, that the findings were "communicated" to the miner. In fact, the presumption under Section 725.308(c) is that every claim is timely. Assuming that access to a report equates to communication by a physician would severely undermine Section 725.308(c). Furthermore, although the miner testified at a deposition on December 11, 2001 as to his treatment for his breathing condition, he made no statement that a doctor had found him totally disabled due to pneumoconiosis. Accordingly, I find that that the miner's testimony also does not support Employer's contention that the instant claim is untimely.

Therefore, concerning timeliness, I have found that the medical reports in the prior claims are not well-reasoned opinions diagnosing total disability due to pneumoconiosis. In addition, I have found that such diagnoses were never communicated to the miner. Either of these findings is independently sufficient to defeat Employer's timeliness contention; thus, this claim was timely filed. Also, although the miner's treating physicians were Drs. Vellayan and Jain, there are no medical opinions from these physicians dated prior to January 20, 1987, the date of the prior denial.

Medical Evidence

Medical evidence submitted with a claim for benefits under the Act is subject to the requirement that it must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. *See* 20 C.F.R. §§ 718.101 to 718.107. The regulations address the criteria for chest x-rays, pulmonary function tests, physician reports, arterial blood

gas studies, autopsies, biopsies and "other medical evidence." *Id.* "Substantial compliance" with the applicable regulations entitles medical evidence to probative weight as valid evidence.

Secondly, medical evidence must comply with the limitations placed upon the development of medical evidence. 20 C.F.R. § 725.414. The regulations provide that a party is limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy and two medical reports as affirmative proof of their entitlement to benefits under the Act. §§ 725.414(a)(2)(i), 725.414(a)(3)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in one single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test or arterial blood gas study. §§ 725.414(a)(2)(ii), 725.414(a)(3)(ii). Likewise, the District Director is subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i-iii). Furthermore, since this the miner's claim is a subsequent claim only evidence submitted after January 20, 1987 will be considered unless a material change in physical condition is proven. 20 C.F.R. § 725.309(d).

X-ray Reports in Miner's and Survivor's Claims[3]

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 13	4/24/02	Hussain	1/0
DX 15	4/24/02	Poulos BCR/B-reader	Film is completely negative
EX 1	6/25/02	Rosenberg B-reader	No abnormalities consistent with pneumoconiosis
EX 4	6/25/02	Halbert BCR/B-reader	No abnormalities consistent with pneumoconiosis

Pulmonary Function Studies in Miner's and Survivor's Claims[4]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 13	Hussain	72/	0.75	2.14	25	35	Yes	Fair effort and

[3] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a) and (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

[4] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c). The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Benefits Review Board (the "Board") has held that a ventilatory study which is accompanied by only two tracings is in substantial compliance with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). The values from the FEV_1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

4/24/02		69”						understanding Pre-bronchodilator[5]
			0.81	2.42		33	Yes	Fair effort and understanding Post-bronchodilator
EX 1 6/25/02	Rosenberg	72/ 69”	0.76	1.20	24	63	Yes	incomplete effort due to shortness of breath
DX 16 9/04/02	Hussain	72/ 69”	0.60	1.73	28	35	Yes	Good cooperation [6]and effort Pre-bronchodilator
			0.65	1.65		39	Yes	Good cooperation and effort Post-bronchodilator

Blood Gas Studies in Miner’s and Survivor’s Claims[7]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise
DX 13	4/24/02	Hussain	46.8	73	R
EX 1	6/25/02	Rosenberg	44.3	70.6	R[8]

Narrative Medical Evidence in Miner’s Claim

Imtiaz Hussain, M.D.[9] examined the miner on April 24, 2002, at which time he took a patient history of symptoms and recorded an employment history of twenty-seven years in coal mine employment. (DX 13). Dr. Hussain noted the miner had a history of wheezing, tuberculosis, arthritis, stroke and black lung disease. He stated the miner was hospitalized thirteen times between 1990 and 2002. He recorded a smoking history of one pack of cigarettes per day between 1945 and 1990. The miner’s symptoms included sputum production, wheezing, dyspnea, cough and ankle edema. In addition, Dr. Hussain performed pulmonary function tests, arterial blood gas studies, a chest x-ray, EKG and physical examination on the miner. Dr. Hussain noted bilateral rhonchi and crackles upon examination of the miner’s lungs. (DX 13).

After reviewing the results of the examination and tests, Dr. Hussain diagnosed the miner with coal workers’ pneumoconiosis 1/0 and chronic obstructive pulmonary disease. (DX 13). He based his pneumoconiosis diagnosis on the miner’s history of exposure and the chest x-ray. Dr. Hussain fails to state a basis for the chronic obstructive pulmonary disease diagnosis. He relates the miner’s conditions to coal dust exposure and tobacco use. In Dr. Hussain’s opinion,

[5] This test was invalidated by Dr. Burki, Board-certified in Internal Medicine and Pulmonary Diseases. He noted that the shape of the graphs indicate inadequate effort.
[6] This test was validated by Dr. Burki.
[7] Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).
[8] Dr. Rosenberg’s arterial blood gas study fails to indicate the altitude level the test was administered. Therefore, the test does not meet regulation requirements and I will give it no weight. *See* 20 C.F.R. § 718.105(c)(2).
[9] Dr. Hussain’s medical qualifications are not included in the record.

the miner has a severe pulmonary impairment due forty percent to pneumoconiosis and sixty percent to chronic obstructive pulmonary disease. He opines that the miner did not have the capacity to return to his regular coal mine employment or comparable employment in a dust-free environment. Dr. Hussain bases this disability finding on the miner's severe dyspnea and hypoxemia. (DX 13).

P.H. Vellayan, M.D.[10] was one of the miner's treating physicians. Claimant submitted a medical report from Dr. Vellayan dated July 12, 2002. (DX 16). Dr. Vellayan recorded an employment history of the miner stating he worked twenty-seven years in coal mine employment. He noted that the miner smoked one to one-and-one-half packs of cigarettes per day between 1946 and 1990. Dr. Vellayan stated the miner had a history of pneumonia, wheezing, tuberculosis, arthritis, stroke and black lung. The miner's symptoms included sputum, wheezing, dyspnea, cough and ankle edema. Dr. Vellayan noted that the miner could not do any physical activity without becoming extremely short of breath. The miner was confined to an electric scooter. Dr. Vellayan performed a physical examination and chest x-ray upon the miner. (DX 16).

Dr. Vellayan diagnosed the miner with pneumoconiosis and chronic obstructive pulmonary disease. (DX 16). He then stated that the miner had an occupational lung disease which was based on the miner's history, chest x-ray and lab data. Dr. Vellayan relates the miner's conditions to coal dust exposure. He also opined that the miner had a severe pulmonary impairment. Dr. Vellayan noted that the miner was totally disabled and did not have the respiratory capacity to perform his usual coal mine employment. He based his opinion on his finding that the miner's physical activity was severely limited. (DX 16).

Claimant also submitted a medical report from the miner's other treating physician, Manuel Jain, M.D.[11] (DX 58). Dr. Jain treated the miner between November 16, 1995 and January 10, 2003. He opined the miner suffered from an occupational lung disease based on the miner's length of coal dust exposure, chest x-ray and his treatment of the miner throughout the years. Dr. Jain relates the miner's respiratory conditions to coal dust exposure. He opined the miner had black lung disease and chronic lung disease due to his exposure. Dr. Jain also found that pneumoconiosis contributed to or hastened the miner's death. However, he provided no basis for this opinion. (DX 58).

David M. Rosenberg, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, examined the miner on June 25, 2002, and issued a medical report on the miner's condition on July 22, 2002. (EX 1). Dr. Rosenberg reviewed the miner's symptoms and recorded an employment history in the underground coal mines for twenty-seven years. He noted the miner smoked one and-one-half packs of cigarettes per day from the age of sixteen until 1990. Dr. Rosenberg noted that the miner informed him that he had a history of shortness of breath upon minimal exertion, frequent respiratory tract infections, cough, sputum production, black lung disease, chronic left posterior chest pain, tuberculosis and pneumonia. He noted the miner was on oxygen and used an electric cart to get around. Upon physical examination, Dr. Rosenberg found the miner became short of breath with minimal activity. He noted the miner's

[10] Dr. Velleyan's medical qualifications are not included in the record.
[11] The record does not include the medical qualifications of Dr. Jain.

lungs revealed diminished breath sounds with marked hyperresonance but without rales, rhonchi or wheezes. Dr. Rosenberg performed a chest x-ray, pulmonary function tests and arterial blood gas studies on the miner. (EX 1).

Dr. Rosenberg stated that although pulmonary function tests were performed, the miner used incomplete effort due to his shortness of breath. The chest x-ray revealed chronic obstructive pulmonary disease. Dr. Rosenberg opined the miner does not suffer from a coal dust exposure-induced condition. He found no conditions associated with coal dust exposure. Dr. Rosenberg relates the miner's chronic obstructive pulmonary disease to smoking. Dr. Rosenberg states "while coal dust exposure can cause COPD, it would not cause a disabling respiratory impairment without the presence of conglomerate CWP." He further opined that the miner is impaired and disabled due to his advanced chronic obstructive pulmonary disease. (EX 1).

Dr. Rosenberg provided two supplemental reports on September 2, 2005 and September 26, 2005. (EX 2, 3). He reviewed the medical evidence of record in forming his opinions. Dr. Rosenberg stated that his opinions remained the same as in his prior report. Furthermore, he found the newly submitted evidence supported his opinion. Dr. Rosenberg stated that the CT scans and chest x-rays showed no presence of micronodularity related to past coal dust exposure and instead revealed severe emphysematous changes correlating with the severe airflow obstruction. He went on to state that the miner's FVC reductions were probably related to air trapping and severe obstruction. As a result, Dr. Rosenberg opined the miner did not have clinical pneumoconiosis. Next, Dr. Rosenberg states the miner did not suffer from legal pneumoconiosis. He stated that based on the miner's "severe airflow obstruction combined with hyperresonance and decreased breath sounds on examination, emphysema roentgenographically, hypoxia and CO_2 retention, all without the presence of micronodularity, are classic for [the miner] having had smoking-related COPD." Dr. Rosenberg opined that the miner died as a result of his smoking-induced chronic obstructive pulmonary disease and not clinical or legal pneumoconiosis. (EX 2, 3).

In addition, the record includes a deposition of Dr. Rosenberg taken on March 14, 2003. (EX 1). Dr. Rosenberg reiterated the findings in his report and further testified to his opinion that the miner did not suffer from legal or clinical pneumoconiosis. Dr. Rosenberg attributes the miner's chronic obstructive pulmonary disease and total disability to smoking based on the pulmonary function testing. (EX 1).

Gregory J. Fino, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, provided a consultative report on September 20, 2005. (EX 6). Dr. Fino reviewed all the medical evidence of record when forming his opinions. He opines that the medical records revealed the miner suffered from a very severe case of emphysema; a significant obstruction based on the pulmonary function testing; chronic obstructive pulmonary disease based on the chest x-rays and CT scans; and, hypercarbia based on the arterial blood gas studies. However, Dr. Fino states that the miner's condition was not related to coal dust exposure. He found no x-ray data to support clinical pneumoconiosis. Dr. Fino opined that coal dust exposure was not a clinically significant contributing factor in the miner's emphysema or chronic obstructive pulmonary disease. He based his opinion on the medical evidence in the record and the medical research studies he reviewed. Dr. Fino found that the miner suffered from a disabling respiratory

impairment and was totally disabled. He noted that the miner could not have performed his prior coal mine employment. However, Dr. Fino attributed the miner's total disability to smoking-induced emphysema. (EX 6).

Claimant also submitted a medical opinion report by Glen Baker, M.D. (CX 3). Claimant designated the report as rebuttal evidence to "other medical evidence" under Section 718.107. A party may offer no more than one physician's assessment of each test or study offered by the opposing party. 20 C.F.R. § 725.414(a)(2)(ii) and (3)(ii)(2001). However, Employer provided no medical evidence under this section to rebut. When formulating his opinions, Dr. Baker took into consideration the opinions of Drs. Halbert, Rosenberg, Vellayan and Jain. Dr. Baker did not review the x-rays or other testing. His opinion is simply rebutting the medical opinion reports and depositions of the other physicians. The regulations limitations on evidence do not allow for rebuttal opinions of medical opinion reports. *See* C.F.R. § 725.414(a)(2) and (3)(2001). Therefore, I cannot take Dr. Baker's report into consideration in either the miner's or survivor's claims.

Narrative Medical Evidence in Survivor's Claim

The medical reports of Drs. Rosenberg, Hussain, Jain and Baker are summarized above.

Claimant designated two medical reports by Dr. Vellayan in the survivor's claim. (DX 55; CX 2). Dr. Vellayan states that the miner suffered from an occupational lung disease related to coal dust exposure. He diagnosed the miner with pneumoconiosis based on the miner's history and his workup over a period of years. Dr. Vellayan related coal dust exposure to the miner's respiratory conditions. He opined that pneumoconiosis contributed to or hastened the miner's death. Dr. Vellayan based his opinion on the miner's frequent hospitalizations and visits and on the fact that the miner was chronically ill. Dr. Vellayan treated the miner between 1980 and October 2002. (DX 55; CX 2).

Lawrence Repsher, M.D., Board-certified in Internal Medicine with a Subspecialty in Pulmonary Diseases, submitted a consultative report. (EX 6). Dr. Repsher reviewed the medical evidence of record in formulating his conclusions. He found the miner worked twenty-seven years in coal mine employment and smoked two packs of cigarettes per day for thirty years. Dr. Repsher noted the miner quit in 1990 but stated he found a notation in the medical records indicating the miner was still smoking in 1994. Based on the evidence he reviewed, Dr. Repsher noted that there was no evidence of clinical or legal pneumoconiosis. He opined that coal dust exposure in no way hastened or related to the miner's death. Dr. Repsher stated that the miner had severe chronic obstructive pulmonary disease but related the condition to smoking. He based his opinion on the pulmonary function testing, chest x-rays and CT scans. Dr. Repsher noted that the chest x-rays and CT scans showed no rounded opacities consistent with clinical pneumoconiosis. He also opined that the miner's other conditions were not related to coal dust exposure but instead were ailments common to the general public at large. Overall Dr. Repsher opined that the miner's smoking history was the most common cause of his chronic obstructive pulmonary disease. He cites six research articles upon which he relied when forming his opinions. (EX 6).

Dr. Repsher then reiterated his findings in a September 22, 2005 supplemental report and deposition taken October 12, 2005. (EX 9). In the supplemental report Dr. Repsher reviewed the other medical evidence in the record. He stated that he continues to opine that the miner's condition was related to smoking and not coal dust exposure. Dr. Repsher stated the same in his deposition testimony. He testified to the differences between smoking and coal dust exposure - induced chronic obstructive pulmonary disease. Dr. Repsher further opined that the miner's death was due to smoking-induced chronic obstructive pulmonary disease and not coal dust exposure. (EX 9).

Hospital and Treatment Records Miner's Claim

The amended regulations provide that, notwithstanding the evidentiary limitations contained at 20 C.F.R. § 725.414(a)(2) and (a)(3), "any record of a miner's hospitalization for respiratory or pulmonary or related disease may be received into evidence." 20 C.F.R. § 725.414(a)(4). Furthermore, a party may submit other medical evidence reported by a physician and not specifically addressed under the regulations under Section 718.107, such as a CT scan.

Claimant submitted the hospital and treatment records from Appalachian Regional Healthcare, Inc.[12] (CX 1). The miner was admitted on December 16, 1990 by Dr. Vellayan. He presented to the hospital with cough and shortness of breath. The physical examination revealed a emphysematous chest, sinus tachycardia, extensive expiratory rhonchi in both lung fields and prolonged expiratory phase. The miner was diagnosed with acute exacerbation of chronic obstructive pulmonary disease, emphysema and pneumoconiosis. He was discharged on December 21, 1990, with instructions to avoid smoke and dust. (CX 1).

William P. McElwain, M.D. admitted the miner on January 2, 1994, with acute bronchitis and exacerbation of chronic obstructive pulmonary disease. (CX 1). Dr. Vellayan then took over the miner's care. The miner complained of shortness of breath and dyspnea at rest. His lungs revealed wheezing at auscultation. The record indicates the miner has a long smoking history but quit three years prior to admission. The chest x-ray read by Ansuya Amin, M.D., revealed chronic obstructive pulmonary disease. (CX 1).

The April 7, 1996 chest x-ray read by Dr. Amin revealed chronic obstructive pulmonary disease. Dr. Amin noted bilateral flattening of the hemidiaphragm and diffuse interstitial fibrosis. (CX 1).

The miner was admitted again on April 15, 1996, for acute exacerbation of chronic obstructive pulmonary disease. (CX 1). His symptoms included shortness of breath, cough, weakness, wheezing, smothering, brown sputum and weight loss with poor appetite. The

[12] Claimant also designated Director's Exhibit 16, a medical report by Dr. Vellayan. However, this report was also designated by Claimant as one of the medical reports she wished to rely on in the miner's claim. Therefore, it has already been summarized above. Furthermore, 20 C.F.R. § 725.414(a)(4)(2001) only allows for admission of hospital and treatment records, not medical reports under this section. Exhibit 16 is a medical report. Claimant also designates Director's Exhibit 11 under this section. This is an exhibit of the miner's death certificate and it is discussed in detail below.

miner's lungs revealed vesicular breathing with prolonged expiration, bilateral scattered rhonchi and occasional basilar crackles. The chest x-ray revealed bilateral flattening of the hemidiaphragm but no acute congestion or infiltration. As a result, Dr. Amin diagnosed the miner with severe chronic obstructive pulmonary disease. Then on April 16, 1996, Dr. Amin performed a CT scan on the miner also revealing severe chronic obstructive pulmonary disease with slight prominent lymph nodes in the hilar region. Upon discharge, Dr. Vellayan diagnosed the miner with acute exacerbation of chronic obstructive pulmonary disease, coal workers' pneumoconiosis, hilar adenopathy and pulmonary hypertension. (CX 1).

Dr. Hussain provided a consultation noting the miner was suffering from severe breathlessness, wheezing, smothering and sputum production. (CX 1). The miner could not walk over ten feet without extreme shortness of breath. Dr. Hussain noted a history of severe black lung disease. Upon examination, Dr. Hussain stated the miner was in respiratory distress. His lungs revealed vesicular breathing with prolonged expiration, bilateral scattered rhonchi and occasional basal crackles. Dr. Hussain opined a chest x-ray revealed severe black lung and chronic obstructive pulmonary disease. The CT scan showed evidence of hilar adenopathy with chronic obstructive pulmonary disease. The physician diagnosed the miner with acute exacerbation of chronic obstructive pulmonary disease, hilar adenopathy, severe black lung and pulmonary hypertension. (CX 1).

On May 17, 1996, Dr. Amin performed a chest x-ray on the miner revealing chronic obstructive pulmonary disease. (CX 1). Dr. Amin noted bilateral flattening of hemidiaphragm and a slight fullness of the superior mediastinum. There was no acute congestion or infiltrate noted. (CX 1).

The May 1996 pulmonary function testing revealed:

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
CX 1 5/30/96	Vellayan	66/ 69"	1.10	1.21	41	90	Yes	Does not indicate effort and cooperation levels

On August 12, 1996, the miner was admitted to the hospital by Dr. Hussain with complaints of breathlessness, cough, wheezing and chest tightness. (CX 1). The physician recorded a history of severe black lung and chronic obstructive pulmonary disease. The examination revealed vesicular breathing, prolonged expiration, bilateral scattered rhonchi, basilar crackles and mildly diminished breath sounds in the right lung base. Dr. Hussain diagnosed the miner with acute exacerbation of chronic obstructive pulmonary disease with black lung. (CX 1).

Dr. Amin diagnosed the miner with chronic obstructive pulmonary disease based on the August 12, 1996 chest x-ray. (CX 1). He noted subtle fullness in the superior mediastinum and apicopleural thickening in the lung apices. There was bilateral flattening of the hemidiaphragm but no acute congestion or infiltration. (CX 1).

Dr. Vellayan diagnosed the miner with chronic obstructive pulmonary disease, emphysema and pneumoconiosis when he was admitted on December 2, 1996. (CX 1). The miner presented with cough, shortness of breath and fever. Dr. Vellayan noted that the miner was disabled due to pneumoconiosis. Upon examination, Dr. Vellayan noted an emphysematous chest, expiratory rhonchi and scattered rales. He indicated the chest x-ray showed chronic obstructive pulmonary disease. (CX 1).

The records also include a consultation performed by Dr. Patel. However, the photocopying and writing are illegible. (CX 1).

On August 18, 1997 the miner was admitted by Dr. Vellayan with complaints of shortness of breath. (CX 1). Upon examination his lungs revealed diminished breath sounds, expiratory rhonchi and scattered rales. The miner was diagnosed with acute exacerbation of chronic obstructive pulmonary disease, emphysema, pneumoconiosis and peptic ulcer disease. The August 18, 1997 chest x-ray revealed flattening of the hemidiaphragm, bilaterally with diffuse interstitial fibrosis and fibrocystic changes in the left upper lobe from an old inflammatory disease. There was no acute congestion or infiltration noted. Dr. Amin read the x-ray and opined the miner suffered from chronic obstructive pulmonary disease. The miner was discharged on August 26, 1997, with instructions to get adequate rest and avoid dusty and smoky environments. (CX 1).

Employer submitted Dr. Jain's November 16, 1995 through January 20, 2003 treatment records of the miner. (EX 7). Throughout the records, the miner's symptoms include cough, shortness of breath, weakness, wheezing, smothering, dyspnea and sputum production. The lung examinations showed diminished breath sounds, rales and rhonchi. Dr. Jain consistently diagnoses the miner with black lung, chronic obstructive pulmonary disease, pulmonary tuberculosis, acute bronchitis and acute exacerbation. However, Dr. Jain never provides a basis for his pneumoconiosis diagnoses. He based his chronic obstructive pulmonary disease and emphysema diagnoses on chest x-ray and CT scan data. However, he never attributed these conditions to coal mine employment. There are no chest x-ray or CT scan findings of pneumoconiosis. The December 23, 2002 chest x-ray indicates the miner had a history of black lung but the note does not state that the film revealed pneumoconiosis. (EX 7).

Dr. Jain treated the miner with oxygen, steroids and other medications. (EX 7). There was one notation on January 26, 2001, indicating cor pulmonale and congestive heart failure; however, Dr. Jain did not state the basis of his opinion, the condition was not attributed to coal dust exposure and the note did not indicate right-sided congestive heart failure. Also, the records are contradictory in relation to the miner's smoking history. On November 28, 1995 Dr. Jain notes that the miner used to smoke but quit; however, on December 17, 1996 he notes the miner was still smoking. (EX 7).

The exhibit includes a pulmonary function test conducted on December 2, 1998.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
EX 7	Dr. Jane	69/	1.01	2.68	34	38	Yes	Pre-bronchodilator Does not indicate

12/02/98		69”						cooperation and effort
			0.99	2.51		39	Yes	Post-bronchodilator Does not indicate cooperation and effort The test also notes that the miner was a smoker of cigarettes and cigars for thirty-five years

Abbas Ali, M.D. provided a consultation on December 24, 2002. (EX 7). Dr. Ali noted the miner complained of shortness of breath. He stated the miner was experiencing cough, chronic obstructive pulmonary disease and exacerbation. Dr. Ali noted a history of black lung disease. Upon examination he noted some wheezes and a barrel chest. In his opinion, the miner suffered from chronic obstructive pulmonary disease. Dr. Ali failed to state the basis of his opinions. (EX 7).

Hospital and Treatment Records Survivor’s Claim

Employer also designated Dr. Jain’s treatment records in the widow’s claim. *See* EX 9. Claimant designated the medical records at Claimant’s Exhibit 1 in the widow’s claim. Since I have already summarized those records above, I will not discuss them again in this section.[13]

On December 3, 1998, Remberto Bitar, M.D. diagnosed the miner with severe obstructive airway disease with compromise of the large and small airways based on pulmonary function testing. (DX 56).

The miner went to the emergency room at Heart of Florida Regional Medical Center on February 14, 1999, and was diagnosed with chronic obstructive pulmonary disease, pneumoconiosis and cerebral arterial occlusion. (DX 56). Dr. Jain notes the miner has a history of smoking and heavy alcohol use. (DX 56).

Adam Griggs, D.O. provided a consult for Dr. Jain. (DX 56). Dr. Griggs noted the miner had a history of pneumoconiosis and his symptoms included shortness of breath and right-sided weakness. He stated a chest x-ray revealed chronic obstructive pulmonary disease and emphysema. Dr. Griggs found the miner used to smoke one-and-one-half packs of cigarettes per day. He diagnosed the miner with chronic obstructive pulmonary disease related to smoking and pneumoconiosis. (DX 56).

[13] Claimant also designated Director’s Exhibit 16, a medical report by Dr. Vellayan in the widow’s claim. However, this report is not a hospital or treatment record. Claimant has already designated her medical reports she wishes to use under 20 C.F.R. § 725.414(a)(2)(i) and (3)(i)(2001). Therefore, Exhibit 16 cannot be taken into consideration under this section. Claimant also designates Director’s Exhibits 11 and 53 under this section. They are exhibits of the miner’s death certificate and it is discussed in detail below. Claimant then designates Director’s Exhibit 54 under the hospital and treatment records section. However, Exhibit 54 is not a medical record, but rather an affidavit from Claimant regarding the miner’s condition, and therefore, it cannot be taken into consideration under this section.

On January 17, 2001, the miner presented to the emergency room for shortness of breath and weakness. (DX 56). The records note a history of black lung disease and chronic obstructive pulmonary disease. The lung examination revealed rales and rhonchi. Dr. Jain diagnosed the miner with chronic obstructive pulmonary disease, black lung and acute exacerbation. (DX 56).

The miner was admitted again on November 10, 2001. (DX 56). The miner's symptoms included shortness of breath, cough, occasional leg swelling, sputum and dyspnea. He was diagnosed with chronic obstructive pulmonary disease with acute exacerbation, atrial fibrillation, aortic valvular disorder and pneumoconiosis. Dr. Jain noted the miner had a history of black lung disease. He stated the chest x-ray revealed chronic obstructive pulmonary disease.

On December 23, 2002, the miner presented to the emergency room with complaints of shortness of breath. (DX 56). Dr. Jain noted a history of chronic obstructive pulmonary disease and black lung. He diagnosed the miner with chronic obstructive pulmonary disease based on the chest x-ray, pneumonia and black lung. (DX 56).

Abbas Ali, M.D. provided a consult for Dr. Jain on December 24, 2002. (DX 56). Dr. Ali noted the miner had a history of black lung disease. The miner's symptoms included shortness of breath and cough. He diagnosed the miner with chronic obstructive pulmonary disease. Dr. Ali stated the miner was at risk for coronary artery disease based on his past smoking history.

An arterial blood gas study was conducted on December 23, 2002.

Exhibit	Physician	pCO_2	pO_2
DX 56	Dr. Cambo	54.5	86
DX 56	Dr. Cambo	65.4	79[14]

The miner was admitted on January 16, 2003, by Dr. Jain. (DX 56). The miner presented with complaints of shortness of breath. The miner's symptoms included dyspnea on exertion, chest pain, shortness of breath, insomnia and anxiety. Dr. Jain's impression upon admittance was that the miner suffered from black lung, chronic obstructive pulmonary disease, pneumonia, hypoxemia and cor pulmonale. He finally diagnosed the miner with chronic obstructive pulmonary disease based on a chest x-ray. He also noted the miner suffered from atrial fibrillation, a decubitus ulcer and black lung disease. (DX 56).

Dr. Bitar provided a consult for Dr. Jain. (DX 56). Dr. Bitar noted the miner had a history of severe obstructive airway disease and black lung. He stated the miner's symptoms included shortness of breath, cough and sputum. Dr. Bitar noted the miner worked twenty-eight years in coal mine employment and smoked a pack of cigarettes a day for twenty years. He diagnosed the miner with acute respiratory insufficiency with acute bronchitic exacerbation of

[14] Dr. Cambo's arterial blood gas studies fail to indicate the altitude level the tests were administered. Therefore, the tests do not meet regulation requirements and I will give them no weight. *See* 20 C.F.R. § 718.105(c)(2).

underlying chronic obstructive pulmonary disease, acute right middle lobe pneumonitis and a history of black lung disease. (DX 56).

The miner had a chest x-ray on January 16, 2003. James Zimmer, M.D. noted the film indicated dyspnea, osteoporosis and pulmonary hyperinflation consistent with chronic obstructive pulmonary disease. (DX 56).

The miner underwent a CT scan of the chest on October 5, 2000. Peter Chirico, M.D. noted emphysematous changes in the lungs with a small area of scarring in the left upper lobe that appeared to have a small nodular component. (DX 57).

On November 27, 2000 Dr. Vellayan admitted the miner to Appalachian Regional Healthcare, Inc. for chronic obstructive pulmonary disease with acute exacerbation. (DX 57). The miner presented with shortness of breath and cough. Dr. Vellayan noted a long history of chronic obstructive pulmonary disease and pulmonary tuberculosis.

The miner was admitted by Dr. Vellayan on September 16, 2002, for pneumonia based on a chest x-ray. (DX 57). He was also diagnosed with chronic obstructive pulmonary disease, atrial fibrillation and pulmonary tuberculosis. The miner's symptoms included shortness of breath and cough. The chest examination revealed emphysematous configuration, scattered rales and extensive expiratory rhonchi. (DX 57).

Death Certificate

The miner died January 31, 2003. (DX 11, 53). Dr. Jain was the physician who signed the death certificate. He noted that the miner's death was caused by black lung and chronic obstructive pulmonary disease. (DX 11, 53).

DISCUSSION AND APPLICABLE LAW MINER'S CLAIM

Because the miner filed his application for benefits after March 31, 1980, his claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations a claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. § 725.202(d)(2)(i-iv). Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989

Threshold Issue for Subsequent Claims

Under the amended regulations of the Act, the progressive and irreversible nature of pneumoconiosis is acknowledged. 20 C.F.R. § 718.201(c). Consequently, claimants are permitted to offer recent evidence of pneumoconiosis after receiving a denial of benefits. *Id.* The new regulations provide that where a claimant files a subsequent claim more than one year after a prior claim has been finally denied, the subsequent claim must be denied on the grounds of the prior denial unless "Claimant demonstrates that one of the applicable conditions of

entitlement has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. § 725.309(d). If a claimant establishes the existence of an element previously adjudicated against him, only then must the administrative law judge consider whether all the evidence of record, including evidence submitted with the prior claim, supports a finding of entitlement to benefits. *Id.* A duplicate claim will be denied unless a claimant shows that one of the applicable conditions has changed since the date of the previous denial order. *Id; see, also Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994).

Accordingly, because the miner's previous claim was denied, Claimant now bears the burden of proof to show that one of the applicable conditions of entitlement has changed. 20 C.F.R. § 725.309(d). I must review the evidence developed and submitted subsequent to January 20, 1987, the date of the prior denial, to determine if the miner meets this burden. *Id.*

The prior denial fails to indicate the elements of entitlement proven by the miner. (DX 1-2, 1-176). Therefore, I will look at the newly submitted evidence to determine whether Claimant has now proven the elements of entitlement. Then if Claimant has proven an element of entitlement, a material change in condition will have been established. I will then reopen the record and take all the new and old evidence into consideration when formulating my entitlement decisions. 20 C.F.R. § 410.410(b).

Pneumoconiosis and Causation

Section 718.202 provides four means by which pneumoconiosis may be established: chest x-ray, biopsy or autopsy, presumption under §§ 718.304, 718.305 or 718.306, or if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a). The regulatory provisions at 20 C.F.R. § 718.201 contain a definition of "pneumoconiosis" provided as follows:

> (a) For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

§ 718.201(a).

It is within the administrative law judge's discretion to determine whether a physician's conclusions regarding pneumoconiosis are adequately supported by documentation. *Lucostic v. United States Steel Corp*., 8 B.L.R. 1-46, 1-47 (1985). "An administrative law judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *See King v. Consolidation Coal Co*., 8 B.L.R. 1-262, 1-265 (1985).

A. X-ray Evidence

Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The chest x-rays in the record do not support a finding of pneumoconiosis. Dr. Hussain found the April 24, 2002 x-ray film positive for pneumoconiosis; however, Dr. Poulos, a Board-certified radiologist and B-reader, found the film completely negative. As such, I find that this x-ray does not support a finding of pneumoconiosis. Dr. Rosenberg, a B-reader, and Dr. Halbert, a Board-certified radiologist and B-reader, both found no abnormalities consistent with pneumoconiosis when reading the June 25, 2002 x-ray. Accordingly, I find Claimant has not established pneumoconiosis under § 781.202(a)(1).

The treatment records in the miner's claim contain ten chest x-ray notations. Only the notation by Dr. Hussain stated a chest x-ray revealed black lung. (CX 1). However, the actual x-ray reading Dr. Hussain refers to is not within the record. No other chest x-ray readings in the miner's claim found pneumoconiosis. Furthermore, none of the x-ray readings were written on ILO forms, provided film quality readings or the reading physicians' credentials. There were numerous readings finding chronic obstructive pulmonary disease and emphysema but the readings did not attribute these conditions to coal dust exposure. Therefore, these films will be granted no weight. Therefore, pneumoconiosis has not been established under § 781.202(a)(1).

B. Autopsy/Biopsy

Pursuant to Section 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. There is no autopsy or biopsy evidence to take into consideration. Therefore, I find Claimant has not proven pneumoconiosis under Section 718.202(a)(2).

C. Presumptions

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

D. Medical Opinions

Section 718.202(a)(4) provides another way for a claimant to prove that he has pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion might support the presence of the disease if it is supported by adequate rationale, notwithstanding a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22, 1-24 (1986). The weight given to a medical opinion will be in proportion to its well-documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director*, OWCP, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 B.L.R. 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*).

The physicians' reports are set forth above. In summary, Dr. Hussain diagnosed the miner with pneumoconiosis. (DX 13). However, Dr. Hussain opined the miner suffered from pneumoconiosis based solely upon the readings of a chest x-ray and the miner's history of dust exposure. (DX 8). In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical

judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone does not tend to establish that he has any respiratory disease arising out of coal mine employment. *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id*.

Acknowledging that Dr. Hussain performed other physical and objective testing, he listed that he expressly relied on the miner's positive chest x-ray and coal dust exposure for his clinical determination of pneumoconiosis. (DX 13). Moreover, he failed to state how the results from his other objective testing might have impacted his diagnosis of pneumoconiosis. As Dr. Hussain does not indicate any other reasons for his diagnosis of clinical pneumoconiosis beyond the chest x-ray and exposure history, I find his report with respect to a diagnosis of clinical pneumoconiosis is unreasoned and I accord it little weight.[15] (DX 13).

Dr. Hussain also diagnosed the miner with chronic obstructive pulmonary disease and emphysema. (DX 13). He based his emphysema diagnose on the chest x-ray but failed to attribute the condition to coal dust exposure. Furthermore, Dr. Hussain fails to provide a basis for his chronic obstructive pulmonary disease diagnosis. Therefore, I find Dr. Hussain's report with respect to a diagnosis of legal pneumoconiosis unreasoned and I accord it little weight. (DX 13).

Dr. Vellayan was one of the miner's treating physicians. (DX 16). He diagnosed the miner with chronic obstructive pulmonary disease and pneumoconiosis. Dr. Vellayan attributed both conditions to coal dust exposure. He based his opinion on the miner's history, chest x-rays and lab data. However, the report does not specify which data and chest x-rays Dr. Vellayan relies upon. There is no objective testing with the report. Also Dr. Vellayan never indicates why or how he attributed the miner's condition to coal dust exposure and not the miner's smoking history. (DX 16). Therefore, I find Dr. Vellayan's clinical and legal diagnosis of pneumoconiosis unreasoned and undocumented.

Claimant also submitted hospital and treatment records from Dr. Vellayan in the miner's claim. (CX 1). Throughout the records Dr. Vellayan consistently diagnosed the miner with pneumoconiosis and black lung disease. However, he never states the basis of his diagnosis. Dr. Vellayan never indicated the tests or data he relied upon when formulating his opinion. Dr. Vellayan also diagnosed the miner with emphysema and chronic obstructive pulmonary disease

[15] Dr. Hussain also diagnosed the miner with pneumoconiosis in the treatment records. However, he also based this diagnosis solely upon a reading of a chest x-ray, and therefore, the opinion is unreasoned.

in the treatment records based on chest x-rays, but he never attributed these conditions to coal dust exposure.[16] Therefore, I give these records little weight.

Dr. Jain opined that the miner suffered from an occupational lung disease based on the miner's length of exposure, chest x-ray results and his treatment of the miner throughout the years. (DX 58). Dr. Jain does not explain how his treatment of the miner contributed to the diagnosis. He states no physical findings or how the miner's symptomatology provided a basis for his opinion. Also Dr. Jain never discusses why he related the miner's condition to coal dust exposure and not smoking. Furthermore, Dr. Jain's report does not provide any documentation to support his diagnoses. Dr. Jain fails to indicate the objective testing he relied upon when forming the opinions in his report. (DX 58). Therefore, I find Dr. Jain's report unreasoned and undocumented and I give it little weight.

The miner's claim also included hospital and treatment records from Dr. Jain. (EX 7). In these records Dr. Jain consistently diagnosed the miner with chronic obstructive pulmonary disease and emphysema. However, in the records Dr. Jain never attributed these conditions to coal dust exposure. Also Dr. Jain stated the miner suffered from pneumoconiosis but he never provided a basis for the diagnosis. (EX 7). Therefore, I give these findings little weight.

In contrast, Dr. Rosenberg's report and supplement reports concluded the miner did not have pneumoconiosis. (EX 1, 2, 3). Although he opined that the miner suffered from chronic obstructive pulmonary disease, he stated that the miner's conditions were not related to coal dust exposure. Dr. Rosenberg related the miner's condition to smoking. He based his opinion on the CT scans and chest x-rays showing no presence of micronodularity related to coal dust exposure and instead revealing severe emphysematous changes correlating with the severe airflow obstruction. Dr. Rosenberg stated that as a result, the miner did not have clinical pneumoconiosis. He then found that the miner did not suffer from legal pneumoconiosis based on the miner's severe airflow obstruction, hyperresonance, emphysema roentgenographically and hypoxia without the presence of micronodularity. Dr. Rosenberg's opinions are consistent with the probative chest x-ray evidence of record. He further explained his findings in his March 14, 2003 deposition. (EX 1). I find Dr. Rosenberg's medical report is well-reasoned and well-documented regarding clinical and legal pneumoconiosis.

Dr. Fino also opined the miner did not suffer from legal or clinical pneumoconiosis. (EX 6). Dr. Fino found that the miner suffered from emphysema and chronic obstructive pulmonary disease. However, he stated that these conditions were related to smoking and not coal dust exposure. Dr. Fino based his opinions on the negative chest x-ray data, lack of evidence connecting the conditions to coal dust exposure and the medical research studies he reviewed and discussed. I find Dr. Fino's medical report is well-reasoned and well-documented regarding pneumoconiosis.

I have considered all the evidence under Section 718.202(a); and I find the probative negative x-ray reports and the more complete, comprehensive and better supported medical

[16] Dr. Vellayan attributed the miner's chronic obstructive pulmonary disease to coal dust exposure in his report; however, I found this report unreasoned and undocumented. Dr. Vellayan failed to connect the medical records to his reasoning in his medical report.

opinion reports of Drs. Rosenberg and Fino outweigh the unreasoned reports and records of Drs. Hussain, Vellayan and Jain and the other contrary evidence of record. Thus, I find Claimant has failed to demonstrate, by a preponderance of the evidence, the existence of pneumoconiosis.[17]

Causation of Pneumoconiosis

Once it is determined that a claimant suffers from pneumoconiosis, it must be determined whether the claimant's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). The burden is upon Claimant to demonstrate by a preponderance of the evidence that the miner's pneumoconiosis arose out of his coal mine employment.
20 C.F.R. § 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arouse out of such employment.

Id.

Since I have found that Claimant failed to prove that the miner had pneumoconiosis, the issue of whether pneumoconiosis arose out of the miner's employment in the coal mines is moot.

Total Disability

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991). A claimant can be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if in absence of contrary probative evidence, the evidence meets one of the Section 718.204(b)(2) standards for total disability. The regulation at Section 718.204(b)(2) provides the following criteria to be applied in determining total disability: 1) pulmonary function studies; 2) arterial blood gas tests; 3) a cor pulmonale diagnosis; and/or, 4) a well-reasoned and well-documented medical opinion concluding total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether Claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1987).

[17] The miner's claim also contains hospital and treatment records from other physicians. (CX 1; EX 7) Throughout the records the physicians diagnose the miner with pneumoconiosis and black lung. However, the physicians never provide a basis for these findings. Also the miner is diagnosed with emphysema, chronic obstructive pulmonary disease and chronic bronchitis, but the physicians do not attribute these conditions to coal dust exposure.

A. Pulmonary Function Tests

Under Section 718.204(b)(2)(i) total disability may be established with qualifying pulmonary function tests.[18] To be qualifying, the FEV_1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1- 154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, I may accord greater weight to the opinion of a physician who reviewed the tracings. *Street v. Consolidation Coal Co.*, 7 B.L.R. 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. *Inman v. Peabody Coal Co.*, 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited poor cooperation or comprehension. *See, e.g., Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984).

The September 4, 2002 pulmonary function study is the only study conforming to the applicable quality standards. The other studies will not be taken into consideration due to the miner's inadequate effort when performing the tests. The September 4, 2002 test produced qualifying values. Accordingly, I find per Section 178.204(b)(2)(i), Claimant has established total disability.

B. Blood Gas Studies

Under Section 718.204(b)(2)(ii) total disability may be established with qualifying arterial blood gas studies. All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1980). This includes testing conducted before and after exercise. *Coen v. Director, OWCP*, 7 B.L.R. 1-30 (1984). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner or circumstances surrounding the testing affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 B.L.R. 1-788 (1984) (miner was intoxicated).

There is only one arterial blood gas study of record conforming to the regulation requirements. However, it produced non-qualifying values. Accordingly, I find Claimant has not proven total disability under Section 718.204(b)(2)(ii).

[18]A qualifying pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A non-qualifying test produces results that exceed the table values.

C. Cor Pulmonale

There is no medical evidence of cor pulmonale in the record, and therefore, I find Claimant failed to establish total disability under the provisions of Section 718.204(b)(2)(iii).[19]

D. Medical Opinions

The final way to establish a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion. The opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. *Id*. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment.
20 C.F.R. § 718.204(b)(2)(iv).

The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. In assessing total disability under Section 718.204(b)(2)(iv), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48, 1-51 (holding medical report need only describe either severity of impairment or physical effects imposed by claimant's respiratory impairment sufficiently for administrative law judge to infer that claimant is totally disabled). Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform comparable and gainful work pursuant to Section 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The physicians' reports are set forth above. In summary, Dr. Hussain performed an employment history upon finding the miner worked twenty-seven years in underground coal mine employment. (DX 13). Dr. Hussain opined the miner suffered from a severe pulmonary impairment which prevented him from having the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. He based his opinion on the miner's severe dyspnea and hypoxemia. (DX 13). Dr. Hussain's diagnosis regarding total disability is well-reasoned and well-documented.

A medical opinion does not have to be wholly reliable or wholly unreliable; rather, the opinion can be divided into the relevant issues of entitlement to determine whether it is reasoned and documented with regard to any particular issue. *See Drummond Coal Co. v. Freeman*, 17 F.3d 361 (11th Cir. 1994); *Billings v. Harlan #4 Coal Co.*, B.R.B. No. 94-3721 B.L.A. (June 19, 1997) (*en banc) (*unpub.). Accordingly, I divide Dr. Hussain's opinions into the relevant issues of pneumoconiosis and total disability. (DX 13). As noted above with respect to pneumoconiosis, Dr. Hussain's report is not well-reasoned. However, in examining the second

[19] There is a notation of cor pulmonale in the treatment records; however, the records do not indicate the basis of this finding. The records merely state a diagnosis of cor pulmonale. Furthermore, there is no indication of right sided congestive heart failure related to coal dust exposure with the diagnosis.

issue of total disability, Dr. Hussain's opinion is supported by objective medical data and testing. Moreover, it is consistent with the other evidence of record.

Dr. Vellayan also concluded the miner was totally disabled. (DX 16). He recorded an employment history of twenty-seven years in coal mine employment. Based on his observations, he determined the miner was unable to perform physical activities due to shortness of breath. Dr. Vellayan opined that the miner was totally disabled due to a severe pulmonary impairment. He stated that he based his opinion on his findings that the miner's physical activity was severely limited. (DX 16). However, Dr. Vellayan's report provides no objective findings or documentation to support his diagnosis. He fails to identify any testing or physical findings upon which he relied. Therefore, I find Dr. Vellayan's total disability opinion unreasoned and undocumented.[20]

Claimant also designated the opinion of Dr. Jain. (DX 58). However, in Dr. Jain's report he makes no total disability findings. Therefore, I give his opinion no weight on the issue of total disability.

Dr. Rosenberg noted the miner worked twenty-seven years in coal mine employment. (EX 1). He found the miner totally disabled but he related the condition to advanced chronic obstructive pulmonary disease related to smoking. Dr. Rosenberg took into consideration all the medical evidence of record. His opinion is consistent with the probative objective testing of record. Dr. Rosenberg further explained his findings and opinions in his deposition dated March 14, 2003 and two supplemental reports. (EX 1, 2, 3). I find Dr. Rosenberg's opinion is well-reasoned and well-documented regarding total disability.

Dr. Fino also opines the miner suffered from a respiratory impairment. (EX 6). Dr. Fino stated the miner was totally disabled and could not perform his regular coal mine employment. He based his opinion on the medical evidence in the record. His opinions are supported by the probative objective testing. I find Dr. Fino's opinion well-reasoned and well-documented regarding total disability.

I have considered all the medical reports and I find Claimant has established total disability by the probative medical opinion reports of record under the provisions of Subsection 718.204(b)(2)(iv).

E. Overall Total Disability Finding

Upon consideration of all of the evidence of record, Claimant has established, by a preponderance of the evidence, total disability. Accordingly, I find Claimant has established total disability under the provisions of Section 718.204(b).

Therefore, Claimant has established a material change in the miner's condition. I must now reopen the record and review the evidence in the previous claims along with the newly

[20] The record includes treatment records from Dr. Vellayan stating the miner is unable to perform physical activity and is totally disabled due to pneumoconiosis. However, he never provides a basis for these findings or documentation to support the opinions.

submitted evidence. The miner filed two previous claims. (DX 1). However, the medical evidence in those claims dates prior to 1988. The Board has held that it is proper to afford the results of recent medical testing more weight over earlier testing. *See Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (granting greater weight to a more recent x-ray); *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-17 (1993) (granting greater weight to a more recent pulmonary function study); *Schretroma v. Director, OWCP*, 18 B.L.R. (1993) (granting greater weight to a more recent arterial blood gas analysis); *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985) (granting greater weight to a more recent medical report). As the medical evidence in the miner's previous claim is over ten years old, I grant greater weight to the newly submitted evidence. Accordingly, I continue to rely on the newly submitted evidence to find that the Claimant has established total disability but not pneumoconiosis as indicated above.

Total Disability Due to Pneumoconiosis

Although Claimant established total disability, Claimant is nonetheless ineligible for benefits because the miner's claim fails to show total disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. *See* § 718.204(c)(2). In interpreting this requirement, the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). There are no well-reasoned and well-documented reports of record regarding total disability due to pneumoconiosis. Although, the reports of Drs. Rosenberg and Fino were well-documented and well-reasoned as to total disability, they attributed the miner's condition to smoking and not coal mine employment. The reports of Drs. Vellayan and Jain regarding pneumoconiosis and total disability were unreasoned and undocumented. Moreover, although Dr. Hussain's total disability opinion was well-reasoned, his pneumoconiosis opinion was not. Therefore, I find that Claimant has failed to establish total disability due to pneumoconiosis.

DISCUSSION AND APPLICABLE LAW SUVIVOR'S CLAIM

Under the applicable regulations, Claimant must establish by a preponderance of the evidence that the miner had pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that his death was due to pneumoconiosis. *See, Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-88 (1993). Failure to establish any of these elements precludes entitlement to benefits. Thus, Claimant widow must demonstrate that the miner had pneumoconiosis, which arose from coal mine employment, and that his death was due to pneumoconiosis in order for benefits to be awarded.

Pneumoconiosis

As in the miner's claim, Claimant must establish pneumoconiosis under 20 C.F.R. § 718.201.

A. X-ray Evidence

As stated above, the chest x-rays in the record do not support a finding of pneumoconiosis. Dr. Hussain found the April 24, 2002 x-ray film positive for pneumoconiosis; however, Dr. Poulos, a Board-certified radiologist and B-reader, found the film completely negative. As such, I find that this x-ray does not support a finding of pneumoconiosis. Dr. Rosenberg, a B-reader, and Dr. Halbert, a Board-certified radiologist and B-reader, both found no abnormalities consistent with pneumoconiosis when reading the June 25, 2002 x-ray. Accordingly, I find Claimant has not established pneumoconiosis under § 781.202(a)(1).

The chest x-rays in the treatment records filed in the survivor's claim also do not support a finding of pneumoconiosis. The treatment records in the survivor's claim contain sixteen notations regarding chest x-rays. However, none of the x-ray readings were written on ILO forms, provided film quality readings or the reading physicians' credentials. Therefore, these films will be granted no weight. Accordingly, pneumoconiosis has not been established under § 781.202(a)(1).

B. Autopsy/Biopsy

Pursuant to Section 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. There is no autopsy or biopsy evidence of record to take into consideration. Therefore, I find Claimant has not proven pneumoconiosis under Section 718.202(a)(2).

C. Presumptions

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

D. Medical Opinions

Section 718.202(a)(4) provides another way for a claimant to prove that the miner had pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis.

The survivor's claim includes the medical reports of Drs. Rosenberg (EX 1, 2, 3), Repsher (EX 6), Hussain (DX 13), Jain (DX 58) and Vellayan (DX 55, CX 2). The pneumoconiosis opinions of Drs. Rosenberg, Hussain and Jain were discussed above. Dr. Rosenberg opined the miner did not suffer from legal or clinical pneumoconiosis. (EX 1, 2, 3). He found the miner's chronic obstructive pulmonary disease was related to smoking. I found his

opinion well-reasoned and well-documented. Dr. Hussain opined the miner suffered from pneumoconiosis and chronic obstructive pulmonary disease related to coal dust exposure. (DX 13). Dr. Hussain relied solely on a chest x-ray and history for his pneumoconiosis diagnosis and provided no basis for his chronic obstructive pulmonary disease diagnosis. Therefore, I found his opinion unreasoned. Dr. Jain also diagnosed the miner with an occupational lung disease based on the miner's length of exposure, chest x-ray results and his treatment of the miner throughout the years. (DX 58). However, Dr. Jain neither explained how his treatment of the miner contributed to the diagnosis nor what physical findings provided a basis for his opinion. I found his opinion unreasoned and undocumented.[21]

Claimant designated two medical reports from Dr. Vellayan in her claim. (DX 55; CX 2). Dr. Vellayan diagnosed the miner with an occupational lung disease based on the miner's past history, chest x-ray and his work-up of the miner throughout the years. However, the reports do not specify which data or chest x-rays upon which Dr. Vellayan relied. The report fails to include objective testing. Dr. Vellayan also fails to state the data he gathered from the miner's work-up upon which he relied to base his opinion that the miner's condition was related to coal dust exposure. Furthermore, Dr. Vellayan never indicates why or how he attributed the miner's condition to coal dust exposure and not the miner's smoking history. (DX 55; CX 2). Therefore, I find Dr. Vellayan's opinion unreasoned and undocumented.[22]

Employer provided a medical opinion report from Dr. Repsher. (EX 6). He reviewed the medical evidence of record in formulating his opinions. He opined that the miner did not suffer from clinical or legal pneumoconiosis. Dr. Repsher noted that the miner suffered from chronic obstructive pulmonary disease but he attributed the condition to smoking. He based his opinion on the negative chest x-ray evidence, CT scans and pulmonary function tests. Dr. Repsher reiterated his findings in his deposition taken October 12, 2005 and supplemental report. (EX 9). Dr. Repsher's opinion is well-reasoned and well-documented.

I have considered all the evidence under Section 718.202(a); and I find the probative negative x-ray reports and the more complete, comprehensive and better supported medical opinion reports of Drs. Rosenberg and Repsher outweigh the unreasoned reports and records of Drs. Hussain, Vellayan and Jain and the other contrary evidence of record. Thus, I find Claimant has failed to demonstrate, by a preponderance of the evidence, the existence of pneumoconiosis in the survivor's claim.[23]

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[21] The survivor's claim also contains treatment records from Dr. Jain. In the records Dr. Jain diagnoses the miner with chronic obstructive pulmonary disease but he never attributes the condition to coal dust exposure. Also there are a couple of notations stating he diagnoses the miner with black lung based on a chest x-ray. However, he provides no other basis for this black lung diagnosis except for the chest x-ray reading. Therefore, the treatment records are unreasoned and undocumented. (DX 56).

[22] Claimant submitted treatment records from Dr. Vellayan in the survivor's claim. Although Dr. Vellayan consistently diagnoses the miner with chronic obstructive pulmonary disease, he never attributes the condition to coal dust exposure in the records. Also he makes numerous notations that the miner has pneumoconiosis or a history of pneumoconiosis; however, he never provides a basis for these opinions. (CX 1, DX 57).

[23] The survivor's claim also contains hospital and treatment records from other physicians. (CX 1; EX 9; DX 56, 57). Throughout the records the physicians diagnose the miner with pneumoconiosis and black lung. However, the physicians never provide a basis for these findings. Also the miner is diagnosed with emphysema, chronic obstructive pulmonary disease and chronic bronchitis, but the physicians do not attribute these conditions to coal dust exposure.

Causation of Pneumoconiosis

Since I have found that Claimant failed to prove that the miner had pneumoconiosis, the issue of whether pneumoconiosis arose out of the miner's employment in the coal mines is moot.

Death Due to Pneumoconiosis

Assuming that pneumoconiosis was established, a claimant must also prove that the miner's death was caused by pneumoconiosis. Under Section 718.205(c), a miner's death is considered to be due to pneumoconiosis in any of the following circumstances: (1) where competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis; or (3) where the presumption set forth at Section 718.304 is applicable. Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition unrelated to pneumoconiosis. 20 C.F.R. § 718.205(c)(4). The presumption at Section 718.304 does not apply to this claim.

Like several other federal circuits, the United States Court of Appeals for the Sixth Circuit has interpreted "substantially contributing cause" to include a hastening of the miner's death. *Griffith v. Director, OWCP*, 49 F.3d 184, 186 (6th Cir. 1995). *See Northern Coal Co. v. Director, OWCP*, 100 F.3d 871, 874 (10th Cir. 1996); *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178, 183 (7th Cir. 1992); *Shuff v. Cedar Coal Co*., 967 F.2d 977, 980 (4th Cir. 1992); Lukosevicz v. Director, OWCP, 888 F.2d 1001 (3d Cir. 1989). This interpretation means that any acceleration of the miner's death that is attributable to pneumoconiosis will entitle Claimant to benefits. *See Griffith*, 49 F.3d at 186.

In order to establish that the miner's death was due to or hastened by pneumoconiosis, a physician's opinion must be adequately documented and reasoned. *See Addison v. Director, OWCP*, 1-68, 1-69 (1988). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*.

The miner died on January 21, 2003. (DX 53). Dr. Jain indicated on the death certificate that the miner died due to black lung disease and chronic obstructive pulmonary disease. (DX 53). However, a death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director*, *OWCP*, 11 B.L.R. 1-68 (1988). Similarly, in *Lango v. Director, OWCP*, 104 F.3d 573 (3rd Cir. 1997), the court adopted the Eighth Circuit's holding in *Risher v. Office of Workers*

Compensation Programs, 940 F.2d 327, 331 (8th Cir. 1991), to state that "the mere fact that a death certificate refers to pneumoconiosis cannot be viewed as a reasoned medical finding, particularly if no autopsy has been performed." *See also Bill Branch Coal Co. v. Sparks*, 213 F.3d 186 (4th Cir. 2000) (a death certificate stating that pneumoconiosis contributed to the miner's death, without future explanation is insufficient). However, the Board has held that a physician's opinion expressed on a death certificate, in addition to his testimony, is sufficient to establish the cause of the miner's death. *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113 (1988).

Dr. Jain was one of the miner's treating physicians between November 16, 1995 and January 10, 2003. (DX 58). Therefore, he had a relationship with the miner and had knowledge of his medical history when he signed the death certificate. However, Dr. Jain's opinion is unreasoned and undocumented. In his medical report he marks that pneumoconiosis contributed to or hastened the miner's death. However, Dr. Jain provides no basis or rationale for this opinion. He also provides no documentation to support his opinion. Therefore, I find his opinion unreasoned and undocumented. (DX 58).

Dr. Vellayan also opined that pneumoconiosis contributed to or hastened the miner's death. (DX 55; CX 2). He based his opinion on the fact that the miner was chronically ill and had frequently been hospitalized. However, Dr. Vellayan's pneumoconiosis opinions were all found to be unreasoned. He doesn't explain how his findings that the miner was chronically ill lead him to believe the miner's death was due to pneumoconiosis. Furthermore, his report provides no documentation for his opinion. Therefore, I find Dr. Vellayan's opinion unreasoned and undocumented.

In contrast, Dr. Rosenberg opined the miner died as a result of smoking-induced chronic obstructive pulmonary disease. (EX 2, 3). Dr. Rosenberg found that the miner did not suffer from pneumoconiosis. He based his opinion on the miner's air flow obstruction, hyperresonance, hypoxia and lack of micronodularity on the chest x-rays and CT scans. Dr. Rosenberg took into consideration all the evidence of record when formulating his opinions. I find Dr. Rosenberg's opinions well-reasoned and well-documented. (EX 1, 2, 3).

Dr. Repsher also opined the miner's death was due to smoking-induced chronic obstructive pulmonary disease and not to coal dust exposure. (EX 6, 9). He found that the miner did not suffer from pneumoconiosis. He based his opinion on the pulmonary function testing, chest x-ray evidence and CT scans. I find his opinion well-reasoned and well-documented.

I have considered all the evidence, and I find the more complete, comprehensive and better supported medical opinion reports of Drs. Rosenberg and Repsher outweigh the unreasoned reports and records of Drs. Vellayan and Jain and the other contrary evidence of record. Thus, I find Claimant has failed to demonstrate, by a preponderance of the evidence, that the miner's death was due to pneumoconiosis.[24]

[24] The survivor's claim also contains numerous hospital and treatment records. (CX 1; EX 9; DX 56, 57). However ,the records never discuss the miner's cause of death.

ENTITLEMENT

Based on the findings in this case, Claimant has not met the conditions of entitlement in either claim. Claimant has not established the presence of pneumoconiosis, that such pneumoconiosis arose out of coal mine employment or that the miner died due to pneumoconiosis. Therefore, both the living miner's and the survivor's claims under the Act shall be denied.

Attorney's Fees

The award of attorney's fees, under this Act, is permitted only in cases in which Claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for the representation services rendered to him in pursuit of the claim

ORDER

It is ordered that the claims of Christine Smith, for the Estate of Edwin Smith, and Christine Smith, widow of Edwin Smith, for benefits under the Black Lung Benefits Act are hereby DENIED.

A

JOSEPH E. KANE
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* C.F.R §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).